

The Status of Dental Care for Prisoners and Ex-Offenders

By

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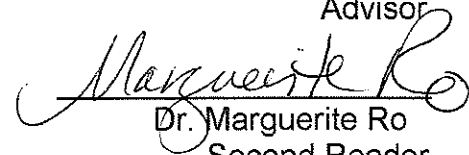
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A report issued February 14, 2007 from the Pew Charitable Trusts makes a sobering statement: by 2011 one in every 178 U.S. citizens will be in prison. The report goes on to state that it will cost \$27.5 billion in spending (mostly in construction costs) over the next five years to house these inmates. (Public Trust, Public Spending: Forecasting America's Prison Population 2007-2011, 2007). The increase is attributed to mandatory minimum prison sentences, reduced parole rates, and increase in recidivism.

In a mid-year assessment (June 2005), the Bureau of Justices Statistics Prison Statistics reported the total number of persons incarcerated in state and Federal prisons (two thirds) or local jails (one third) as 2,186,230, an increase of 2.6% from 2004 (Justice, 2007). Among males in their late 20s, nearly 12% of African American males were incarcerated, along with 3.9% of Hispanic males and 1.7% of White males. The incarceration rate of men rose 1.9%. Many of these men come into prison with existing health issues, including dental problems.

It is estimated that 46 million Americans under the age of 65 lacked health insurance in 2005. Many of these Americans are middle income, most are the working poor. Some of these Americans are ex-offenders, attempting to get their lives back as honest tax-paying citizens. Yet there are several barriers: lack of housing, employment, insurance, drug addiction and inability to get treatment are just a few.

For most, prison or jail is not a permanent home and every day thousands of inmates are released back into society. Since limited data exists on health care specifically for this group, for the purpose of this paper, statistical data and

research regarding low-income communities will be referenced as research for this population.

Oral health is a significant factor in general health but everyone does not have the same access to health care, specifically dental care. Many people do not have access to dental care, attributed to barriers such as socio-economic status and transportation. Low income communities of color have limited access to health and oral care. Good oral care serves as the basic building blocks for good general health and impacts so many determinants of quality of life – including self esteem and the likelihood of finding or maintaining a job. Poor oral health can lead to tooth decay and gum disease which impacts the ability to eat and process nutrients. In rare instances, the lack of appropriate and timely treatment can lead to death, as in the case of a Maryland twelve year old who died as a result of bacteria from an abscess tooth (Otto, 2007). Poor health impacts school, work, family, and sometimes life itself.

This cycle of poor oral health is common – limited access to oral care prior to incarceration, with inmates reporting to jail or prison with dental cavities, missing teeth, or gum disease. This can lead to overall poor health status of inmates and contributes to health and economic problems for ex-offenders. The monetary and human costs of treating inmates' health problems are enormous. For example, the state of California spends more than \$1.1 billion a year on prison health care (Sterngold, 2005). Preventable diseases and health ailments such as chronic mouth pain and diseases such as diabetes are further complicated due to inadequate dental care.

The purpose of this study is to examine oral health care for prisoners and ex-offenders. This study will:

- examine access to dental care relative to need as defined by oral health status
- determine policy options to expand oral health care for prisoners and ex-offenders
- develop policy recommendations to assure that there is appropriate access to oral health care by prisoners and ex-offenders

Background

The prison population

According to the Federal Bureau of Prisons (BOP), as of December 2006, 193,045 men are confined to a federal prison. The majority of those in federal prison are male (93.3%), with an average age of 38, and 40.3% African-American (Prison, 2007). The majority of BOP inmates serve a sentence of five to ten years (29.6%), to be released back into society. The majority of BOP inmates were convicted of drug offenses (53.7%). As many as 2,186,230 Americans were in state, federal or local jails in mid-June 2005.

A growing number of women find themselves incarcerated as well. The number of women confined to state or federal prison increased by 2.6% from year ending 2004, reaching 107,518 (Justice, 2007). The Pew study predicts a growth of 16% of women prisoners over the next five years.

Many of those who are more likely to be incarcerated come from a life of poverty and missed opportunities. On average, families living below the poverty

level experience more dental decay than those who are economically better off (General, 2000) Those entering prison bring their health challenges with them, into a system that is more often than not unprepared or have inadequate systems to meet such challenges.

Low income

Ex-offenders are more likely to have little to no financial resources, characteristics of low-income individuals. As mentioned, for the purpose of this research, data regarding low income, uninsured, or underinsured will be used to define research and policy recommendations for ex-offenders.

The US Census Bureau's 2005 American Community Survey Data shows 10.2% families and 13.3% individuals live below the poverty level (defined as following the Office of Management and Budget's (OMB's) Directive 14. The Census Bureau defines poverty by income threshold that varies by family composition. . If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being "below the poverty level." (Bureau, 2005)

Oral health

In 2000 a groundbreaking report was released by the US Surgeon General on the status of our nation's oral health (General, 2000). The report was a first in that it outlined how oral health is essential to general health. The report also highlighted some disparities in terms how all Americans are not achieving the same level of care. The message conveyed is that oral health is more than teeth – but a major determinant of health and quality of life. The report also connected

oral health to other “mouth issues” including cancers, lesions, birth defects such as cleft lip and palate and other diseases that represent a broader picture of oral health.

Among the many highlights of the report:

- Dental caries (tooth decay) is the most common childhood ailment – five times more common than asthma. Poor minority children are more likely to have severe dental caries.
- There is a strong correlation between poverty and dental disease.
- Severe periodontal disease affects fourteen percent of adults aged 45 to 54.
- For every adult nineteen years or older without medical insurance, there are three without dental insurance.
- For the year 2000, it was estimated that the cost of dental care would exceed \$60 billion (not including lost time from work or school due to pain).
- Statistics show a higher percentage of women (67%) visit the dentist at least once a year, in comparison to men (63%).

African Americans have a higher rate of missing teeth when compared to non-Hispanic Whites. African American males have the highest risk of oral cavity and pharyngeal cancer, with a survival rate of less than five years – which makes early detection very important (General, 2000).

Dental insurance is also important – because cost is a deterrent for many to seek dental care, particularly those in low income and underserved populations. The type of insurance can determine whether a dentist decides to provide care.

For example, many dentists do not take Medicaid due to a large amount of paperwork or low reimbursement rate (Otto, 2007). The Otto article also noted the challenge of finding a dentist nearby; and without reliable transportation, many forgo the effort all together. Other barriers include inability to take time off from work or for many, the motivation to not lose pay or the perception that the problem is not great enough to necessitate a visit to the dentist.

Methodology

This study examines national data from a variety of sources, including newspaper articles, journal articles and special reports produced by universities, government agencies, health organizations, or non-profit entities.

Definition of terms

Oral Health –The US Surgeon General Report defines oral health as healthy teeth and “being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues, collectively known as craniofacial complex.” (General, 2000)

Prison –a place in which individuals are physically confined, and usually deprived of personal freedoms. Prisons are institutions which form part of the criminal justice system of a county, such that imprisonment or incarceration is a legal penalty that may be imposed by the state for the commission of a crime.

(Wikipedia)

Jail –a place under the jurisdiction of a local government (county) for the confinement of persons awaiting trial or those convicted of a minor crime.

(Merriam-Webster)

Department of Correction –Government agency at the state level charged with the management of jails and prisons.

Prisoner co-pay – The amount a prisoner must pay to receive services. The state usually provides a certain amount of funding for prison health care, or some combination of state and federal funding. The co-pay is a minimal amount of cash that a prisoner provides in order to receive services.

Dental Caries – also described as tooth decay, is an infectious disease which damages the structure of teeth. The disease can lead to pain, tooth loss, infections and in severe cases, death. (Wikipedia)

Limitations of the research

Overall there is limited research on the status of oral health for prisoners and little research regarding dental health that is specific to ex-offenders.

Research Questions

What access to oral health services do prisoners and ex-offenders have?

There is no standard of providing oral health care for prisoners. Because there is no generalized framework, the variance of care provided is great. Most prison systems conduct a screening where the inmate is interviewed regarding medical history and current health needs. The interview is followed up one to two weeks later with a physical exam by a physician and screening for mental illness,

substance abuse, etc, as well as an exam by a dentist to identify oral health needs (Anno, 2004).

An analysis of the North Carolina Department of Corrections conducted by First Health of the Carolinas in 2005 shows there are forty dental clinics in a system of 75 prisons. The dental health program has a budget of \$6.5 million, which is comparable to the size of the state and the number of inmates it serves (38,309 inmates and 113,817 probationers and 2896 parolees as of April 7, 2007). There are 36 dentists on staff and the program had 65,518 dental visits in 2004. The process to access dental service is the inmate completes a sick-call form that is reviewed by the nurse triage unit. The nurse schedules appointments and makes transportation arrangements if necessary (Leopper, 2006)

Despite the US Supreme Court's ruling that to deny access to health care to inmates may be cruel and unusual punishment, prisoners are not guaranteed access to dental care (Anno, 2004). A 1996 survey sent to Departments of Corrections in all 50 states plus the District of Columbia determined that 79% (37 out of 50) Department of Corrections provided some form of dental hygiene services. Forty-five percent of the states returned surveys, or a response rate of 88%. The mechanism to cover the expenses of these services range from state financial support to fifty one percent (24) requiring a co-payment from prisoners (Makrides & Shulman, 2002).

The process to receive dental care varies per prison. Standard requirements or benchmarks for dental and medical care vary per prison and jail system. Prisoner access to dental services varies from written requests to sign-up

sheets. Prison standards do exist in that inmates must have the opportunity to request health services on a daily basis with requests to be viewed by a health professional within 24 hours of receipt of the request. However, service may not be provided right away due to limited number of physicians or dentists.

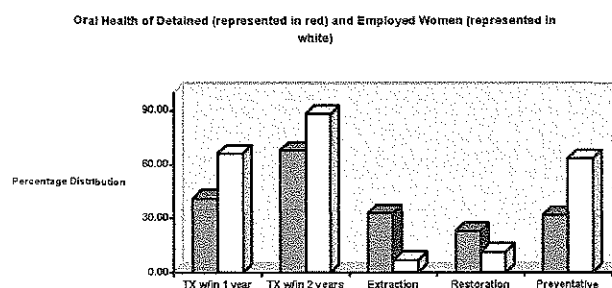
For ex-offenders, there are re-entry programs that attempt to connect ex-offenders with services such as housing, employment, and limited medical services in the form of free health clinics. Some clinics are mobile, making it easier for ex-offenders to receive services. Local health department or community centers may provide services on a particular day of the week. Some services are free, although most clinics charge a small fee.

Is there appropriate access to oral health services relative to need?

Most inmates are from low income communities – the same communities that lack easily accessible, affordable dental care. Many go into prison with dental cavities and experience aggravation of pre-existing conditions. Further problems occur due to lack of immediate attention. People with poor dental hygiene experience gastric or nutritional problems because they can not chew foods properly. Poor oral health has a greater impact on quality of life and well being. The Surgeon General's report discussed poor oral health's impact on social functions such as communication, eating in public, being intimate, smiling, and securing jobs. For prisoners, social interaction with other inmates and prison guards, the fear of being teased or assaulted because one's appearance is not of the norm (society's definition of normal appearance is a mouthful of clean, white teeth) and dealing with constant pain.

Several studies support the theory that women have more decayed and filled teeth than men and they are more likely to make frequent trips to the dentist than men (Badner & Margolin, 1994). The Badner and Margolin article demonstrates that detained women reported their last visit to the dentist was for a tooth extraction and they did not receive routine dental care. During a dental health screening, 32.7% (out of sample size of 183) reported they had oral pain at the time of the screening. African American women had more decayed and missing teeth than Hispanic detained women (there were too few detained white women to make a statistical comparison).

The study also makes a point of comparing detained women versus working women. The detained women (less likely to have a high school diploma, more likely to be single) had more instances of extraction and less likely to have had a recent dental visit.



(Badner & Margolin, 1994)

A ten-year study in a large penal system in Texas demonstrates the effectiveness of routine dental programs. The study offered levels of care: primary, secondary and tertiary. Primary is defined as “personal and professional efforts to prevent disease. Secondary is defined as “treatment of early disease to prevent further progress of potentially irreversible conditions”. Tertiary

preventative care is provided when the disease has set in, for example, missing teeth. Secondary and tertiary have the same result – pulling teeth. Prisoners at the Texas Department of Criminal Justice –Institutional Division received the use of fluorides, sealants and steps on how to brush and floss teeth. Cavities were filled or procedures such as extraction of teeth or root canals were performed. With this support, inmates were more “motivated” towards better care and the number of dental appointments decreased (Meyers, 1999).

What policies and programs are needed to assure appropriate oral health services for prisoners?

A limited review exists on the status of prison oral health. In 1996 a national survey was sent to state departments of correction to determine the level of prison oral care, ratio of dentists to inmates and how such care was covered (Makrides & Shulman, 2002). Survey instruments were sent to all fifty states plus the District of Columbia. A response rate of 90% was achieved.

The results of that review show the majority of DOC have (72% or 33 who answered the survey) have a dental director who is fulltime. Only 11% provide clinical care. Few had a health service administrator who managed dental care. Only ten DOC had a separate budget set aside specifically for dental programs – most did not have a resource allocation in place. In fact, over half of the DOE require a co-payment for services – as a way to demonstrate to the public that prisoners do not have access to “free services”.

In terms of systems, many departments of corrections contract out all or a portion of services provided to area providers. For example, the dental health

program of the North Carolina Department of Corrections is contracted out to area providers and an area dental school. The contracts are monitored by the department of corrections. Even so, the program has a challenge with maintaining staff due to low salaries.

Policy Recommendations

The public should recognize the importance of providing health care, particularly dental care, to prisoners and ex-offenders. The current state of health care – where 46.1 million people are uninsured, where the gap between African Americans and whites regarding access to regular health care is widening, where the costs of health care are rising faster than the average worker's salary – magnifies the need to focus on shifting the paradigm of care in this country. The recognition is everywhere in terms of the need to improve access to health care. Beginning with the neediest members of our society is a starting place. Incarcerated men and women return to their communities and families. Their health impacts their ability to work, impacts their families, and impacts their ability to start the path towards becoming productive citizens.

What are the reasons for the problem of inadequate dental care for prisoners and ex-offenders? A variety of factors contribute to this problem. Beginning with life outside of the prison, accessibility to regular, affordable dental care is non-existent to a large segment in this country. We have determined that African American men make up 12% of the prison population, and growing due to the war on drugs with the end result of life behind bars. African-Americans have the lowest median income for 2005, \$30,858.

Statistically, the higher the income, the more likely a family had health insurance coverage – 91.5% households with incomes of \$75,000 or more had health insurance. The number of uninsured remained unchanged for Whites and African-Americans between 2004 and 2005, but rose among Hispanics to 14.1 million (compared to 22.1 million Whites and 7.2 million African-Americans) (DeNavas-Walt, Proctor, & Lee, 2006). Without health insurance there is limited access to dentists. Some are able to afford the cash payments to dentists but for the majority of Americans, this is not an option.

A Kaiser report on the elimination of adult dental coverage in Massachusetts reveals some of the barriers to dental care for the working poor. In 2002 the state began eliminating adults from Medicaid dental coverage due to the state's financial shortfalls. Further cuts were made through 2004. Lack of access to dental care is illustrated by the fact that of the 5000 practicing, private dentists in the state, only 795 received reimbursements from the state's MassHealth program. In 2004, the number fell to 678. (Pryor & Monopoli, 2005)

Eighty percent of the 46.1 million people without health insurance are eligible for public health insurance coverage or live in families with income 300% below the poverty level. Of the uninsured 25% are eligible for Medicaid (Holahan, Cook, & Dubay, 2007). Medicaid, a federal program, is available to families with an income at or below 200% of the poverty level (or \$30,134 for a family of four in 2004). Children, parents of dependent children, the elderly and people with disabilities are eligible for coverage. States have the option to expand Medicaid income eligibility beyond the federal minimum standards, but can not use federal

matching funds to cover childless adults. Coverage includes hospital services, physician, midwife, and certified nurse practitioner services, laboratory tests, nursing home and home health care for adults over the age of 21 and screening and family planning. States have the option of using federal dollars to support dental services and prescription drug benefits (Kaiser, 2007).

Once inside prison, access to dental care depends on the correctional facility – there is no standard followed by every prison in regards to providing services beyond a routine pre-admission exam.

Stakeholders

Who are the stakeholders? The issue of dental care for prisoners and ex-offenders has many stakeholders. Obviously, prisoners are stakeholders because their health is dependent upon receipt of services. Prison guards are stakeholders because they are charged with daily interactions with inmates and maintaining a safe environment is crucial for the safety of the inmates and prison staff. Tax payers are very important stakeholders. Tax dollars largely support the public funding of medical care. It is estimated that in 2003 national spending for health care was \$1.67 trillion, or \$5,670 per person. Ninety-six percent of Medicare spending and 83% of Medicaid spending is for people with chronic health conditions (Fierro, 2006).

Other stakeholders include families, ex-offenders, insurance providers, dentists, hygienists, dental schools, and the community at large. Families are stakeholders because they may be dependent on income from ex-offenders, and also they seek the best interests for their loved ones. Ex-offenders are obvious

stakeholders in that they are the target population and are in need of services to provide dental care services. Insurance providers are stakeholders because they are an important link of care and have a direct impact on whether services will be covered, dentists who will be reimbursed for service provided, and the requirement of co-payment. Insurance companies maintain costs and largely define who they serve. Dentists, hygienists are providers of care and have an ethical obligation to place the welfare of their patients above any other considerations. (ADA Principles of Ethics and Code of Principal Conduct). In addition to educating future dental professionals, dental schools are being more involved with community health centers and correctional facilities (such as in North Carolina) to develop leadership and creative solutions to broaden dental services. Public health departments and community health centers provide services to many, and expand opportunities for low-income residents to have access to medical and dental care. The community-at-large is a very important stakeholder in that society benefits most from healthy, productive individuals with a quality of living that affords them to be active members with their families and communities.

Recommendations

Every prisoner should have access to basic preventative care, not limited to signing a sheet of paper and waiting days for an answer. In cases where the correctional facility is in a rural area where there are not enough dentists or dental hygienists, financial incentives should be given to entice dentists and hygienists to perform a minimum number of hours at a correctional facility. At a

minimum, every inmate should receive a toothbrush and toothpaste, along with instructions on how to clean teeth. In the North Carolina prison system, the greatest need is for root canals, which is a costly procedure. The dental health program is taking a proactive stance and are demonstrating best practices for oral hygiene for inmates in the hopes of increasing the knowledge of inmates' ability to care for their teeth (Leopper, 2006)

To address the limited number of dentists in correctional facilities, **states could train non-violent inmates in minimum security prisons to serve as dental hygienists** to treat other inmates, while under supervision. Once the trained inmates are released, they can be hired for a minimum number of years as dental hygienists for correctional facilities, thereby increasing the number of hygienists available to provide dental services to prisons. In places where there are dental schools, the state can negotiate financial incentives for dental schools to train non-violent inmates in minimum security prisons. Incentives for the student are scholarships or payment of student loans. Incentives for inmates include learning a rewarding trade, some form of health coverage upon release from prison, and a steady source of income.

Correctional facilities should work with community-based organizations and institutions such as hospitals and clinics, to coordinate health and dental care to ex-offenders upon their release from prison. Many community-based organizations have developed innovative programs to address unmet needs in communities and can serve as an important resource for ex-offenders.

We must **make better use of dental schools by allowing dental students to provide routine preventative care to prisoners and ex-offenders.** Dental schools are excellent resources for states that have a limited amount of resources. Many states, such as North Carolina, have contractual agreements with dental schools to provide clinical rotation opportunities to students and to fill the gap in services to prisoners. Students are supervised by a qualified physician and students learn with valuable hands-on experience.

There is a need to **expand public assistance or provide temporary financial assistance to adults who are among the poorest in this country.** States must take on a greater responsibility to ensure basic health coverage for those who are below the federal poverty level. Ex-offenders, who experience a challenge when released from prison to locate steady work, health coverage, and drug abuse counseling, could be covered through a mixture of state and private business dollars to support a state-based universal health coverage benefit to reduce the number of uninsured Americans. Such coverage will also educate and provide preventative health and dental services to reduce the number of individuals suffering from chronic illnesses. As stated before, the majority of medical expenses, private and public, are directed at dealing with chronic diseases, most of which could have been prevented.

Federal prisons must demonstrate leadership by **establishing standards for contractual services** to provide health care for federal facilities. At present there is no standard or reporting mechanism for businesses awarded federal contracts to provide health and dental services to prisons. Such standards can

serve as benchmarks for state facilities. The state of California's Department of Corrections and Rehabilitation managed the state prison medical care budget that was so mismanaged, it was put under receivership to the care of an outside medical evaluator who is tasked with correcting vast mismanagement of state dollars and inadequate services that failed to provide the constitutional protected service for inmates (Richman, 2006). In addition to **regular reporting requirements** (to include a status of medical care provided, equipment purchased, staff and cost of service), standards should require the **minimum salary** of staff to be comparable to similar contracts to reduce staff attrition and **involvement of community-based organizations** as a resource to reduce tax-payer burden.

Stakeholder Support

Not every stakeholder will support all of the above policy recommendations. The most challenging to garner stakeholder support is the recommendation to increase public assistance to the poorest in this society. The American culture prides itself with the "pulling oneself up by the bootstrap" philosophy. The pervasive attitude is that individuals must provide for themselves and should be able to locate jobs that provide health insurance coverage. Statistics show the number of employers that provide basic health insurance dropped from 59.8% to 59.5 (DeNavas-Walt, Proctor, & Lee, 2006), with a growing number of small businesses unable to provide health insurance premiums for its employees. The cost of health care is going up, rising faster than overall income (Fierro, 2006). The ranks of the uninsured and underinsured are rising, which necessitates creative thinking. Public financial assistance could be

financed with state and private business support (pharmaceutical companies or health care industry). Assistance could be provided for a set period of time to allow ex-offenders and other low income adults time to secure jobs that offer secure health care benefits.

The policy recommendation that will be the easiest to garner stakeholder support is the recommendation to establish standards for contractual services provided to federal and state prisons. California represents the biggest picture of waste, fraud, and abuse of the taxpayers dollars. Some examples of waste include the San Quentin prison ordering gastroenterology diagnostic imaging equipment four years ago, receiving the equipment two years ago, but placed in storage because the “floor of the room in which it was to be installed couldn’t bear the weight” (Richman, 2006). Community members, families, politicians, every tax payer can rally behind an effort for greater accountability and oversight of prison health care services.

Conclusion

The status of oral health care provided to prisoners is in need of corrective action. The current mechanism varies across prison systems, without standards or oversight. Some states, such as North Carolina, are offering creative approaches to address this challenge, however there is a greater need to focus attention and resources to implement leadership at the state and federal levels to ensure adequate care and attention is provided. Policy changes are necessary to address the need for prisoners and ex-offenders, particularly as the prison population

continues to grow and these individuals join our society, seeking ways to become productive and healthy citizens.

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